**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

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|---|---|
| Requestor Name and Address:<br>HARRIS METHODIST FORT WORTH<br>3255 W PIONEER PKWY<br>ARLINGTON TX 76013 | MFDR Tracking #: M4-06-6157-01<br>DWC Claim #:<br>Injured Employee: |
| Respondent Name and Box #:<br>LIBERTY INSURANCE CORP<br>Box #: 28 | Date of Injury:<br>Employer Name:<br>Insurance Carrier #: |

## PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Requestor's Position Summary:** "This patient had 2 outpatient surgery procedures done. The primary procedure was APC 227-which Medicare would allow $8882.35 for. The second was APC 223, which they would allow at $1413.42 X 50%=$706.71. (There were also implants used during the surgery, but those were paid for correctly the by the insurance carrier.) This comes to $9589.06 for the APC's alone. Allowing this at 140%, which has become a standard acceptable rate of fair and reasonable, would come to $13,534.68. We believe the carrier should pay at least the full APC rates for the 2 procedures."

**Amount in Dispute:** $12,416.68 ($13,534.68 - $1,118.00)

## PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Respondent's Position Summary:** "The bills have been re-reviewed and our position remains the same." "Per the UB92, the claimant was admitted on July 18, 2005 @ 0500 hrs and discharged July 19, 2005 @ 1000hrs. This is over 23 hours. Per the Texas Acute Care Inpatient Fee guidelines anything over 23 hr mark is considered an inpatient status." Liberty Mutual does not believe that Harris Methodist Fort Worth Hospital is due any further reimbursement for services rendered to [claimant] between dates of service 7/18/05-7/19/05."

## PART IV: SUMMARY OF FINDINGS

| Date(s) of Service | Denial Code(s) | Disputed Service | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| 7/18/2005 through 7/19/2005 | G, 97, X094, M, W10, Z585, F, W1, Z560, Z922, Z652, X598 | Inpatient Surgery | $12,416.68 | $0.00 |
| | | | **Total Due:** | $0.00 |

## PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on May 22, 2006. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on June 1, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - G, 97, X094-Charges included in the facility fee.
   - M, W10, Z585-The charge for this procedure exceeds fair and reasonable.
   - F, Z560-The charge for this procedure exceeds the fee schedule or usual and customary allowance.
   - Z922-Outpatient bill processed using 23 hour rule payment.

- F, W1, Z652-Recommendationof payment has been based on a procedure code which best describes services rendered.
- X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

2. Division rule at 28 TAC §134.401(b)(1)(B), effective August 1, 1997, states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(10), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." A review of the submitted medical records supports that the claimant's length of stay exceeded 23 hours; therefore, this admission is an inpatient per Division rule at 28 TAC §134.401(b)(1)(B).
3. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401."
4. The requestor states in the position summary that "There were also implants used during the surgery, but those were paid for correctly the by the insurance carrier." Therefore, the reimbursement for the implants is not in dispute.
5. Division rule at 28 TAC §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118.00."
6. The hospital admission was from 7/18/2005 through 7/19/2005; therefore, the length of stay was one day.
7. Per Division rule at 28 TAC §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore, 1 X $1118.00 = $1,118.00. The insurance carrier paid $1,118.00. The difference between amount due and paid is $0.00; this amount is recommended for reimbursement.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.401
Texas Government Code, Chapter 2001, Subchapter G

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services involved in this dispute.

**DECISION:**

| | | |
|---|---|---|
| | | **10/18/2010** |
| Authorized Signature | Medical Fee Dispute Resolution Officer | Date |
| | | **10/18/2010** |
| Authorized Signature | Medical Fee Dispute Resolution Manager | Date |

**PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**